STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

MEMORANDUM

DATE: January 23, 2017

TO: Family Planning Coordinators/Executive Directors

FROM: Deanna Charest, Manager
Reproductive and Preconception Health Unit
Division of Maternal and Infant Health

SUBJECT: MDHHS Title X Family Planning Standards & Guidelines Manual, 2017 and Contraceptive and STD Protocol Templates for 2017 Updates - FP-129-17

Please note that the updated MDHHS Title X Family Planning Standards and Guidelines Manual is now posted on the Family Planning website: www.Michigan.gov/familyplanning. Click on the Information for Providers button.

A list of changes to the manual is attached to this notice. Major changes include updated requirements for conducting Information and Education (I&E) Committee review and approval of materials, new general consent requirements, improved chlamydia screening for pregnancy testing and contraceptive services, and Zika virus education and screening in core family planning services.

Also, newly posted on the Family Planning website are approved contraceptive and STD protocol templates for 2017, developed with the direction of the Family Planning Advisory Council (FPAC) Medical Advisory Committee. Changes to these protocols include the integration of Zika virus education, screening and referral, as appropriate. Other changes are contraceptive eligibility recommendations reflecting the July 2016 updates to the CDC Medical Eligibility Criteria (MEC) and to the CDC Selected Practice Recommendations (SPR)

https://www.cdc.gov/reproductivehealth/contraception/usmec.htm
https://www.cdc.gov/reproductivehealth/contraception/usspr.htm

The 2017 STD protocol for Gonorrhea now includes an alternative regimen for patients with allergy to cephalosporins.

If you have questions please contact your consultant, Darin McMillan, McMillanD@michigan.gov, Jessica Hamel, hamelJ5@michigan.gov , Quess Derman, dermanb@michigan.gov, or Sue Montei, montei628@gmail.com

Changes to MDHHS Title X Family Planning Standards and Guidelines 2017

There are minimal changes to the Standards and Guidelines for 2017. The basic structure of the 2016 Guidelines remain. The major changes are responses to the MDHHS Federal Review of 2016, resulting in revision of I & E requirements and additions to general consent for services requirements. Changes to Chlamydia screening requirements and additional QFP integration, such as discussion on contraceptive counseling and achieving pregnancy, are also added. Below is a list and location of changes to the manual.

1. Clarification of the Public Health code mandate regarding family planning services (p. 7)
2. OPA Program priorities for 2017 and Key Issues for 2017, with an increased focus on integration of QFP and reproductive life plan/reproductive intention (pp. 24,25)
3. OPA Program policy notice issued Nov. 2016 Integrating with Primary Care (pp. 27-30)
4. All resource links in manual checked & updated. Added Zika links from OPA and CDC (p. 33)
5. Michigan Annual Health Care Plan Instructions for 2016 (pp. 54-55)
6. Addition of requirements to General Consents for Services to include that services are voluntary without coercion and without prerequisite. (p. 66)
7. Clarification of requirements for I. & E. committee membership, process for review and approval of educational materials, and documentation of the committee's approval of materials. (pp. 76-78)
8. General consent for services requirements include voluntary, without coercion or prerequisite and confidentiality states in clinical section. (pp. 86)
9. Client encounters for women and men of reproductive age should include a zika virus risk assessment asking about past travel and future travel plans for both client and partner(s). Page 86
10. Zika risk assessment, screening consideration, education and prevention strategies have been added to the medical history, laboratory, and education/counseling requirements for contraceptive, preconception health, achieving pregnancy, pregnancy diagnosis and counseling, basic infertility, and STD services. (pp. 90-103)
11. Requirement that chlamydia testing be offered annually for all females <25 and women $\geq$ 25 who are sexually active and with risk factors added to the contraceptive services and pregnancy diagnosis & counseling sections. (pp. 92, 98)
12. Elements of quality contraceptive counseling added to contraceptive services section (p. 93)
13. Achieving Pregnancy Services section has been updated to better reflect the QFP. (pp. 96-98)
14. Clarification of Hepatitis B screening recommendations (based on QFP update of 2015) has been added to the STD section. (p. 103)
15. Added Zika Virus to STD section (p. 103)
16. Clarification that both the medical director and prescribing practitioner names are needed on the prescription labels (p. 107)
17. Update to description of the Michigan FPAC (p. 121)

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

Date: February 1, 2017

To: Health Officers/Executive Directors

From: Brenda Fink, ACSW, Director
Division of Maternal and Infant Health

Subject: Request for Proposals (RFP) – Title X Community Outreach Mini-Grants – FP-130-17

The Michigan Department of Health and Human Services (MDHHS) is pleased to offer a one-time mini-grant of up to $30,000 to fund up to seven current Title X sub-recipients to implement evidence-based community outreach strategies or promising practices that are focused on, but not limited to 1) increasing a target population's access to family planning services, 2) expanding the preconception and reproductive life planning knowledge and behavior of a target population, 3) increasing community awareness and messaging for family planning services, and 4) coordinating outreach and education efforts with health plans to increase contraceptive access.

In an effort to build upon and leverage existing community-based efforts to reduce infant mortality through reducing unintended pregnancy, fostering preconception health, promoting access to reproductive health services, and encouraging interconception care, applicants can receive preferential scoring by 1) selecting a Michigan county or city with an infant death rate above the state rate of 6.8 per 1,000 live births and 2) targeting a population at-risk of infant mortality.

To apply for this funding opportunity, Title X sub-recipients must submit an application, as outlined in the attached RFP and supporting documents. The MDHHS requests that applicants submit (via email) an "Intent to Apply" form (Appendix A) by 5:00 p.m. on Friday, February 17, 2017. Submission of the "Intent to Apply" form is non-binding. ***Full applications are due by 11:59 p.m. EST, on Friday, March 3, 2017***. Please note, the formatting of this RFP has changed, however, the content remains virtually identical to the 2016 grant.

Any questions concerning the content of this RFP must be sent via email to Jessica Hamel at hamelj5@michigan.gov on or before February 10, 2017. Questions must be emailed during the designated dates only. MDHHS will compile all relevant questions and answers and send these as well as any other clarifications or revisions to the initial RFP by February 13, 2017 by email to all Family Planning Coordinators. No individual responses will be provided.

We are pleased to offer this opportunity to Title X sub-recipients to identify outreach methods that are effective or hold promise for increasing access to family services and promoting the benefits of the program.

cc: Family Planning Coordinators

Michigan Title X Family Planning Program

PROPOSAL COVER SHEET

Agency: **DUNS Number:**

Address: **FEIN Number:**

City: **State:** MI **Zip Code:**

Authorized Representative: **Phone:**

E-Mail Address:

Contact Person: **Phone:**

E-Mail Address: **Fax:**

Project Name:

Service Area(s):

Target Audience(s):

Intervention Method(s):

Estimated Reach of Target Audience Members:

Total project cost: $

Michigan Title X Family Planning Program Assurance of Compliance:

A. Not provide abortion services as a method of family planning or use project funds to pay for abortions.
B. Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning.
C. Adhere to all other assurances as written in your original Title X Family Planning Program contract.
D. All information contained in this proposal is truthful and accurate.

Signature: _____

Authorized Representative:

Title: Date:

Michigan Title X Family Planning Program

Public Act 360 (2002) Section 333.1091 Assurance Form

Michigan Department of Health & Human Services
Division of Maternal & Infant Health
Family Planning Program Provider Certification

Name of Agency: _____

Address: _____

_____

_____

Service Area: _____

Name of Counties Served: _____

Pursuant to PA 360 (2002) Section 333.1091, I certify that this agency (Please initial applicable choice):

_____ Qualifies as a priority family planning provider because we do not engage in any of the activities outlined in PA 360 (2002) Section 333.1091.

_____ Does not qualify as a priority family planning provider because we engage in the activities outlined in PA 360 (2002) Section 333.1091.

I attest that I am authorized to sign on behalf of this agency and that I will notify the Michigan Department of Health and Human Services in writing should the status of any of the above conditions change.

Print Name: _____

Title: _____

Sign: _____ **Date:** _____

Michigan Title X Family Planning Program

COMMUNITY OUTREACH MINI-GRANT
YEAR-END PROGRESS REPORT REQUIRED FORMAT

Narrative Instructions

I. Program Description
   a. Provide a brief overview of the project, including target population(s), service area(s), outreach method(s), and estimated reach.
   b. Highlight significant project achievements, milestones, or other notable accomplishments during the budget period.
   c. Highlight project challenges or barriers encountered during the budget period and how they were addressed.

Work Plan Instructions

I. Project Activities
   a. Include a copy of your agency's submitted work plan, noting progress toward each objective and work plan elements. Please highlight quantitative (i.e., brochures distributed, population reach, events held, attendance, etc.) and qualitative (i.e., participant feedback) measures. This information will be used to demonstrate the success of this funding opportunity when reporting back to the CDC.

Program Goal:
Goal should be time-framed and measurable.

Objectives:
Objectives should be time-framed, measurable, and relate to accomplishing the stated goal.

Services/Activities	Person Responsible	Timeframe	Evaluation Methods	Evaluation Measures	Expected Outcomes	Progress Report
Describe services and activities in enough detail so that it is clear WHAT the activity entails including number of participants, name of the activity (if applicable), frequency and duration of service/activity and any other supporting information that will provide reviewers with a clear picture of the day-to-day service/activity that will be provided. It is helpful to point out if the activities are integrated or linked to other	Clearly identify the person(s) responsible for carrying out each service/activity described. Please provide titles/positions, not names of individuals.	Provide a time frame for implementing each service/ activity described	Describe evaluation methods that will be used to evaluate the proposed services/ activities.	Describe the measures that will be used to evaluate the proposed services/ activities.	Describe the change(s) that will occur as a result of the proposed services/ activities.	*NOTE*: This column can be added to your previously submitted work plan to reduce reporting burden. Please be sure to include 'Year-End Progress Report' in that document's title, along with Program Description narrative.

Michigan Title X Family Planning Program

REQUIRED COMMUNITY OUTREACH WORK PLAN TEMPLATE

Program Goal: Goal should be time-framed and measurable.					
Objectives: Objectives should be time-framed, measurable, and relate to accomplishing the stated goal.					
Services/Activities	**Person Responsible**	**Timeframe**	**Evaluation Methods**	**Evaluation Measures**	**Expected Outcomes**
Describe services and activities in enough detail so that it is clear WHAT the activity entails including number of participants, name of the activity (if applicable), frequency and duration of service/activity and any other supporting information that will provide reviewers with a clear picture of the day-to-day service/activity that will be provided. It is helpful to point out if the activities are integrated or linked to other services/activities in your plan. Your services and activities should be clearly linked to your program goal and one or more of the stated objectives. One service/activity may relate to accomplishing more than one objective.	Clearly identify the person(s) responsible for carrying out each service/activity described. Please provide titles/positions, not names of individuals.	Provide a time frame for implementing each service/ activity described	Describe evaluation methods that will be used to evaluate the proposed services/ activities.	Describe the measures that will be used to evaluate the proposed services/ activities.	Describe the change(s) that will occur as a result of the proposed services/ activities.

Michigan Title X Family Planning Program

INTENT TO APPLY FORM

Agency: **DUNS Number:**

Address: **FEIN Number:**

City: **State:** MI **Zip Code:**

Contact Person: **Title:**

Phone: **Fax:**

E-Mail Address:

Proposed Geographic Location: *(check all that apply)*

☐Alcona County	☐Delta County	☐Keweenaw County	☐Oakland County
☐Alger County	☐Dickinson County	☐Lake County	☐Oceana County
☐Allegan County	☐Eaton County	☐Lapper County	☐Ogemaw County
☐Alpena County	☐Emmet County	☐Leelanau County	☐Ontonagon County
☐Antrim County	☐Genesee County	☐Lenawee County	☐Osceola County
☐Arenac County	☐Gladwin County	☐Livingston County	☐Oscoda County
☐Baraga County	☐Gogebic County	☐Luce County	☐Otsego County
☐Barry County	☐Grand Traverse County	☐Mackinac County	☐Ottawa County
☐Bay County	☐Gratiot County	☐Macomb County	☐Presque Isle County
☐Benzie County	☐Hillsdale County	☐Manistee County	☐Roscommon County
☐Berrien County	☐Houghton County	☐Marquette County	☐Saginaw County
☐Branch County	☐Huron County	☐Mason County	☐St. Clair County
☐Calhoun County	☐Ingham County	☐Mecosta County	☐St. Joseph County
☐Cass County	☐Ionia County	☐Menominee County	☐Sanilac County
☐City of Detroit	☐Iosco County	☐Midland County	☐Schoolcraft County
☐Charlevoix County	☐Iron County	☐Missaukee County	☐Shiawassee County
☐Cheboygan County	☐Isabella County	☐Monroe County	☐Tuscola County
☐Chippewa County	☐Jackson County	☐Montcalm County	☐Van Buren County
☐Clare County	☐Kalamazoo County	☐Montmorency County	☐Washtenaw County
☐Clinton County	☐Kalkaska County	☐Muskegon County	☐Wayne County
☐Crawford County	☐Kent County	☐Newaygo County	☐Wexford County

Project Name:

Funding Request: (Maximum $30,000) $

Signature Date

EMAIL COMPLETED FORM TO: Judy Stiles at stilesj@michigan.gov

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

DATE: February 9, 2017

TO: Family Planning Coordinators/Executive Directors

FROM: Deanna Charest, Manager
Reproductive and Preconception Health Unit

SUBJECT: Family Planning General Consent Minimum Requirement Templates – FP-131-17

To ensure general consent forms used for reproductive health services within Michigan's Family Planning network reflect Title X minimum requirements (See 2017 Standards & Guidelines Manual, Sections 8.1.iv (Voluntary Participation), 10.2 (Confidentiality), and 20.A.1 (Client Encounter)), the Michigan Department of Health and Human Services (MDHHS) is requesting all Family Planning agencies update their general consent forms to include the following components about family planning services: 1) provided on a voluntary basis, without coercion to accept any method; 2) not used as a prerequisite for receipt of any other services offered at the agency; and 3) provided in a confidential manner, noting any limitations that may apply, such as exceptions required by law.

Family Planning agencies that do not provide any other services outside of family planning may omit the prerequisite for receipt of any other services language from their general consent forms. For Family Planning agencies that use a multi-program general consent form, a family planning program section must be included, and at minimum, address Title X minimum requirements.

To assist Family Planning agencies with this request, the MDHHS has developed a family planning general consent form template (See Attachment A). This template may also be found on the MDHHS Family Planning website under the 'Information for Providers' section. If your agency's general consent form already addresses Title X minimum requirements, no action is needed.

If you have any questions regarding this request, please contact your agency consultant Barbara Derman at dermanb@michigan.gov or 517-335-8696, Darin McMillan at mcmilland@michigan.gov or 517-335-8891, or Jessica Hamel at hamelj5@michigan.gov or 517-335-9263.

General Informed Consent

I willingly ask the Health Department for family planning services.

Family planning services may include my body being checked out, my blood drawn, my urine tested, or being given medication or birth control.

I understand staff will not bully or force me to accept services, use a certain type of birth control, or choose a specific pregnancy option.

I realize the medication or birth control I receive today could have side effects and I could still become pregnant. I agree to assume responsibility for those risks.

I understand that I do not need to receive family planning services to get other services or support from the Health Department.

The things I share and services I get today will be kept private and will not be shared with anyone else unless I say they can or is required by law.

The things I said about how much money I make are truthful. The amount of money I make determines if I pay for services today or not. I will not be denied services if I cannot pay.

The things I share about my health today are truthful. If I am told I need to see another doctor, I will be responsible for calling and paying that doctor.

I will call the Health Department if I have side effects with the medication or birth control I am given.

I know I can ask Health Department staff questions at any time and will be given information that is truthful and clear.

I can ask for a copy of this form.

By signing this form, the Health Department can share my information, as needed.

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

MEMORANDUM

TO: Health Officers and Chief Executive Officers/Directors
Title X Family Planning Programs

FROM: Deanna Charest, Manager
Women's Reproductive Health Unit
Division of Maternal and Infant Health

DATE: February 21, 2017

SUBJECT: Request for FY '16 Family Planning Cost Study – FP-132-17

The Family Planning Program is conducting a FY '16 Cost Study by using our Cost Analysis Tool that was developed and designed to help Family Planning agencies set their billing rates to a level that meets their cost of providing services. This Tool has been offered as a resource for agencies that may not have a cost analysis process in place or have been cited during an audit for insufficient billing rates.

The purpose of the Family Planning Program Cost Analysis Tool is to produce a reasonable estimate of the cost of services at Title X funded agencies throughout Michigan. This Cost Analysis Tool uses the "Relative Value Method" of assigning costs to each CPT code used by each agency. The relative value method is a cost accounting technique used to assign costs to distinct procedures.

Relative values are determined by medical professionals, who after extensive study, assign a relative value number to each CPT code. This value expresses the relative relationship between CPT codes in terms of labor, supplies, and overhead costs needed to complete each procedure. A procedure that uses more resources would be assigned a higher relative value than a procedure that uses fewer resources to complete. The relative values used for this Cost Analysis Tool were obtained from CMS (Centers for Medicare and Medicaid) for 2017. This information is updated every calendar year.

The Family Planning Program would like your participation in conducting this Cost Study and to use Family Planning data and financial information from Fiscal Year 2016 (FY '16) October 1, 2015 to September 30, 2016.

Please complete the Cost analysis Tool Excel file and submit it is back to MDHHS by May 31, 2017, or sooner, and early involvement and submission is encouraged.

Please see the PDF file called: FY '16 Family Planning Cost Analysis Tool Instructions Summary that will provide guidance on how to use the Cost Analysis Tool. This instruction summary references the following files:

Attachments:

- Cost Analysis Tool 2017 (Excel File)
- The Basics RVU's (PDF)
- A Guide to Cost Analysis - Allocation of Costs (PDF)
- Time Study Example Sheet (Excel File)

If you have any questions regarding the Cost Analysis Tool, please feel free to contact Steve Utter at 517-241-0114 or utters@michigan.gov

Thank you.

Cc: Family Planning Coordinators
Family Planning Advisory Council

PROGRAM BUDGET SUMMARY

View at 100% or Larger
Use WHOLE DOLLARS Only

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

ATTACHMENT B.1

PROGRAM			DATE PREPARED		Page	Of
GRANTEE NAME			BUDGET PERIOD From: To:			
MAILING ADDRESS (Number and Street)			BUDGET AGREEMENT ☐ ORIGINAL ☐ AMENDMENT		AMENDMENT #	
CITY	STATE	ZIP CODE	FEDERAL ID NUMBER			

EXPENDITURE CATEGORY				TOTAL BUDGET (Use Whole Dollars)
1. SALARY & WAGES				
2. FRINGE BENEFITS				
3. TRAVEL				
4. SUPPLIES & MATERIALS				
5. CONTRACTUAL (Subcontracts/Subrecipients)				
6. EQUIPMENT				
7. OTHER EXPENSES				
8. **TOTAL DIRECT EXPENDITURES** (Sum of Lines 1-7)				
9. INDIRECT COSTS: Rate #1 %				
INDIRECT COSTS: Rate #2 %				
10. TOTAL EXPENDITURES				

SOURCE OF FUNDS:

11. FEES & COLLECTIONS				
12. STATE AGREEMENT				
13. LOCAL				
14. FEDERAL				
15. OTHER(S)				
16. TOTAL FUNDING				

AUTHORITY: P.A. 368 of 1978 **COMPLETION:** Is Voluntary, but is required as a condition of funding.	The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

DCH-0385(E) (Rev. 08/15) (Excel) Previous Edition Obsolete.

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

MEMORANDUM

DATE: March 22, 2017

TO: Family Planning Coordinators/Executive Directors

FROM: Deanna Charest, Manager
Reproductive and Preconception Health Unit

SUBJECT: Family Planning Service Site Changes FP – 133-17

In order to maintain an accurate record of current Michigan Title X services sites, the Michigan Department of Health and Human Services (MDHHS) expects sub recipient agencies to provide timely notice of any additions, deletions, or changes to street address for Title X service sites. MDHHS requests a minimum of 30 days advance notice of these changes. As the Title X grantee, MDHHS is required to provide notice to the Office of Population Affairs.

Please also remember to provide updated contact information, email addresses and phone numbers of your agency's designated family planning coordinator.

Upon notice of service site or contact changes, MDHHS will provide updates to the Title X database. Your local agency is responsible for submitting all changes to the 340B program per program requirements, which are available at http://www.hrsa.gov/opa/programrequirements/.

Service site and/or contact changes can be sent to your agency consultant: Darin McMillan at mcmilland@michigan.gov, Barbara "Quess" Derman dermanb@michigan.gov, or Jessica Hamel at hamelj5@michigan.gov

Thank you in advance.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

MEMORANDUM

DATE: March 24, 2017

TO: Family Planning Coordinators/Executive Directors

FROM: Deanna Charest, Manager
Reproductive and Preconception Health Unit

SUBJECT: Title X Outreach & Enrollment Data Collection 2017 – FP-136-17

To assist the Office of Population Affairs' (OPA) assessment of Title X service sites' 2016-2017 contributions to Medicaid and Marketplace efforts, the Michigan Department of Health and Human Services (MDHHS) is requesting all Title X sub-recipients submit outreach and enrollment data for each Title X service site for the period of April 1, 2016 through March 31, 2017. Outreach and enrollment data are to be submitted to OPA by April 30, 2017 via SurveyMonkey: https://www.surveymonkey.com/r/2017OEdata

All outreach and enrollment activities that occur at a Title X service site should be reported, regardless of funding source. A service site is defined as a Title X-funded clinic. For example, if a Title X sub-recipient has three Title X-funded clinics, three outreach and enrollment surveys will need to be submitted.

The outreach and enrollment survey will ask each Title X service site to report on the following items from April 1, 2016 through March 31, 2017:

- Number of enrollment workers present at the Title X site
- Number of individuals assisted by enrollment workers at the Title X site
- Number of individuals who received an eligibility determination with the assistance of a trained enrollment worker at the Title X site
- Number of individuals enrolled by a trained enrollment worker at the Title X site
- Barriers and lessons learned by the service site

Included with this memo is a FAQ document on common questions regarding outreach and enrollment data collection, as well as a PDF version of the 2016-2017 Outreach and Enrollment Survey. Title X services sites are strongly encouraged to prepare their responses prior to entering their data into SurveyMonkey.

If you have questions or concerns about how survey terms are defined, OPA's 2014-2015 Outreach and Enrollment Data Collection webinar and slide deck are available at: http://www.fpntc.org/event/outreach-and-enrollment-data-collection-webinar

Title X Network Enrollment Data Collection FAQs

***Data Due for all Title X service sites via SurveyMonkey: April 30, 2017**

FAQ's updated: January 10, 2017

Section 1: Guidance on How to Complete the OPA Enrollment Data Collection Survey

Q1: I heard that there was a webinar on Title X enrollment assistance data collection – where can I find a recording of this webinar?

A1: OPA has held two webinars for the Title X network on how to report health insurance enrollment efforts that have occurred at Title X service sites. The first webinar was held on November 10, 2014, and a recording of this webinar is archived on the Enrollment Assistance Community of Practice on fpntc.org. The second webinar was held on March 17, 2015, and can be found on the homepage of fpntc.org. All members of the Title X network who are involved in enrollment assistance as either assisters or data reporters are encouraged to watch either of the webinars – they contain the same content, so you may decide to watch either recording.

All Title X enrollment assisters are encouraged to create an account on fpntc.org and join the Enrollment Assistance community of practice. You can find a number of helpful enrollment resources, post discussion topics, and ask questions to the community and OPA. Please ensure you review the webinar for all Title X grantees and not for the enrollment assistance grantees, which have separate requirements.

Q2: The reporting period for the Title X Network data collection is April 1, 2016 – March 31, 2017, but I do not know whether my service site has enrollment data that goes back to April 2015. Do you have any suggestions for finding out this information?

A2: OPA understands that some service sites did not conduct enrollment efforts in 2016-2017 and/or may not have been tracking enrollment encounters with their clients after the end of the first open enrollment period. If the service site did not track this data and has no way of estimating it, just submit the data you did collect. **If your service site conducted zero enrollment activities during the data collection period you must still complete one survey for the site.**

Section 2: Who Needs to Complete the Survey and Which Data Should Be Included?

Q3: I have a site that does not do any enrollment of any kind. Should they still submit a form even though all of the info will be zero?

A3: Yes, each site must submit a completed survey form, even if they enter zeros for every question. Having each site submit a form, regardless of whether there was any enrollment activity, helps OPA ensure that we have an accurate denominator for the number of clinics in our network.

Q4: We have one Admin Site in the network of Title X sites that we (as grantees) oversee. Should they complete this data collection survey?

A4: A service site is either a clinic or a center that provides clinical care. If this administrative Title X site doesn't see patients or does not have existing or potential Title X clients visit to obtain enrollment assistance, then they do not need to submit a form. We would like a form from every service site that sees patients.

Q5: If we are a Title X sub-grantee with two clinics, do we submit two forms?

A5: Correct, each of the two clinics would submit its own survey form. A sub-grantee or grantee may choose to submit one form on behalf of each service site, or the service site may respond to the survey directly.

For example: If you are a grantee and have 10 sub-recipients with 10 sites each—your network of service sites would need to submit 100 completed surveys (one survey per clinic). As a Title X grantee, you may decide to delegate the task of responding to the survey to a sub-grantee or directly to the service site.

Q6: Do Title X sites located and operating in U.S. territories have to complete the survey?

A6: No, Title X sites located and operating in U.S. territories do NOT have to complete the survey.

Q7: If a clinic does not have any on-site assistance workers, but they are distributing information about enrollment, will they be expected to report using the survey in April 2017?

A7: Yes, all Title X service sites (clinics) must submit a completed survey, regardless of whether they conducted enrollment activities during the reporting period.

Q8: If my service site does not have any trained assistance workers and we referred patients to an external organization for help with enrollment; do we record any of these efforts?

A8: You are still required to submit a completed survey to OPA, but you would not count referrals to another organization in any of the data collection categories (i.e., report zeros in the survey). Only count enrollment efforts conducted by staff who received training to assist and enroll consumers. Such activities must have occurred at your Title X service site. Disseminating information (handing out brochures) or referring patients to another organization does not count as assisting consumers.

Q9: Does the OPA data reporting survey have to be completed by health center managers, or can the assistance workers at my service site fill it out?

A9: The data collection survey link will be sent to every Title X grantee and grantees will decide whether to fill out one survey for each of their service sites, or whether to pass the link on directly to the Title X service site for completion. Anyone with knowledge of the enrollment data may complete the survey, as long as they have a good understanding of the measures being asked. It does not have to be a manager at the service site.

Q10: There are a few FQHCs in my network and they have their own reporting requirements for HRSA to report similar enrollment data. Do these FQHCs need to report the same data to HRSA and to OPA? How do we avoid double counting?

A10: Yes, FQHCs that receive Title X funds should report **all** enrollment activities that occurred at their site to OPA. When presenting results of this survey, OPA will add a disclaimer to acknowledge that service sites may have reported the same data to other federal offices. OPA will use the data collected to provide us with an estimate of the impact that Title X service sites had on enrolling existing and potential Title X clients.

Q11: Will OPA expect FQHCs to determine the difference between assisting a Title X user versus a regular FQHC patient?

A11: No, sites can report the aggregate number of patients/consumers assisted at the Title X-recipient service site. They do not have separate Title X versus non-Title X clients.

Q12: If a Title X clinic borrows certified enrollment assistance staff from another agency and those workers visit our clinic two days per week, can we count clients enrolled at our site in OPA reporting?

A12: Yes, it is acceptable to count consumers enrolled at Title X service sites even though the certified enrollment workers may be paid by other agencies/organizations. We want to capture the number of existing and potential Title X clients who were assisted and enrolled through a Title X site. Tracking enrollment data from shared assisters may be complicated, though, and you would want to ensure that assisters from the separate agency have a way to tell you how many consumers were assisted and enrolled just at your service site.

Q13: My service site is not legally allowed to report the number of people enrolled in a health insurance plan due to state-enacted legislation. We can still assist consumers in educating them about programs, though. How should we report data in this scenario?

A13: You should fill out the survey with as much data as you have. You will likely be able to answer the questions around the number of trained assistance workers you had present at your clinic, as well as how many consumers you assisted for the various insurance plan options in your state. Report zeros for the categories that do not have any data (such as the number of eligibility determinations issued or number of consumers enrolled). On the final page of the survey, in the narrative section, you can note that your state legislation prohibited you from tracking enrollments.

Q14: If my state doesn't require any special training for Medicaid or partial Medicaid, but clinic staff assist and enroll clients in those programs, do we count the number of people we assisted/enrolled in reporting?

A14: Yes, if your clinic staff do not have to be trained to assist consumers with enrollment into Medicaid programs in your state, you should include those individuals assisted, determined eligible, and enrolled in Medicaid or partial Medicaid with the help of such staff in the OPA data reporting.

Q15: My state doesn't allow our clinic staff to enroll clients into Medicaid (clients need to tum in their own forms to Medicaid), but our clinics assist clients by helping them fill out the paperwork. Do we count these activities in OPA reporting?

A15: Yes, the activities described in the above scenario qualify as assists. In the survey, you would report having a large number of assists, but a low (or zero) number of enrollments because you are unable to

track those enrollments. In such a case, you can use the narrative section of the form to explain the reason for the discrepancy between the number of assists and the number of enrollments in your clinic.

Q16: What if we have a sub-grantee that is conducting enrollment activities outside of their Title X clinic, such as at their immunization clinic?

A16: You should only report data for enrollment activities that occurred as part of the Title X service site's efforts. If your service site refers consumers out to another clinic that is not affiliated with Title X, you would not count that consumer in any of the reporting for your service site. Alternatively, if your Title X service site has trained assisters on staff who went to community events to work with consumers, you would count any resulting assists or enrollments in data reporting. Those assistance staff are affiliated with the Title X clinic, and thus contribute to the reporting.

Q17: If we assist a consumer who is outside of the Title X demographic, should we count them in the enrollment data reporting?

A17: Yes, you would count such individuals in reporting for OPA because Title X-supported staff worked directly with the consumer. It is important to note that assisters should help consumers of all ages who approach them for assistance with health insurance enrollment.

SECTION 3: DATA DEFINITIONS AND HOW TO COUNT INDIVIDUALS

Q18: How is OPA defining an individual as being "assisted" and can we count encounters that occur over the phone or by email?

A18: OPA is defining the "number of individuals assisted by a trained outreach and enrollment assistance worker" as an individual who received one-on-one or small group education tailored to the needs of each consumer. Assistance should include in-person education about affordable insurance coverage options (one-on-one or small group) and any other assistance provided to facilitate enrollment, e.g., setting up an account, filing affordability assistance information, receiving an eligibility determination, and/or selecting a qualified health plan or Medicaid/CHIP plan. You may count individuals who receive assistance in-person, over the phone, by email, or other two-way communication method in Title X reporting. The OPA definition of "assisted" aligns with the definition used by HRSA and other federal agencies.

Q19: How is OPA defining a consumer as "enrolled" in a health insurance plan with the assistance of a certified enrollment worker?

A19: OPA and other federal agencies are considering a consumer to be enrolled in a health insurance plan if the certified assistance worker has worked with the consumer to determine the plan that suits the consumer's needs, the consumer selects a plan, and the individual commits to enrolling/paying the premium. Because there is often lag-time between when the consumer selects the plan and signs up for the insurance and the time that the first payment is due for the premium, it is often not possible to conduct the follow-up that would be necessary to determine whether that consumer actually pays for the plan. Remember, the Federally-facilitated, Partnership, and State-based Marketplaces track whether consumers pay for their premiums, and the Marketplaces maintain official numbers for consumers enrolled in those health insurance plans.

Q20: We have a State-based Marketplace through which people can enroll in most Medicaid programs or Qualified Health Plans (if ineligible for Medicaid). When you say "Marketplace," are you referring to the Qualified Health Plans only?

A20: Yes, we are referring to insurance plans offered by the Federally-facilitated Marketplace (found on healthcare.gov) or by your State-based Marketplace.

Q21: If a clinic has staff who are not trained in the Marketplace (i.e., they are not certified application counselors or certified assistance workers), but staff do education and outreach for state-based Medicaid or other state programs, can they be counted as assistance workers for reporting purposes?

A21: If your state does not have training requirements for Medicaid or another state special health insurance program and your staff conduct education and/or enrollment activities with Title X clients, you can count those specific staff as assistance workers trained in Medicaid or partial Medicaid only. Only count the staff that work directly with clients for these programs – do not count every staff at the service site just because they are *technically* able to work with clients for Medicaid.

Q22: When filling out the number of trained assisters we had on staff during the reporting period, do you want us to count the percentage of an assistance worker's time if they only worked for part of the reporting period?

A22: Just report them as 1 assistance worker. We're asking for whole numbers – the number of trained assistance workers, not FTEs.

Q23: If the number of assistance workers we have has fluctuated over time, what number of workers would I report when I complete the survey?

A23: Count the maximum number of workers you had at any point during the reporting period who participated in enrollment activities at your service site.

Q24: My state has one application for our full state Medicaid program as well as for the state's Family Planning Waiver program. There is no distinction between the two programs on the application. How would we count those individuals we helped to enroll by filling out the application?

A24: Count individuals that you assisted/enrolled in this scenario as having enrolled in full Medicaid (the higher coverage option of the two program options).

Q25: If an individual is presumptively determined eligible for the state's Family Planning Waiver program and then is later approved for ongoing eligibility, how would we count this enrollment?

A25: You would count this person in the following categories:

- 1b one individual assisted (total number)
- 1b one individual assisted for partial Medicaid ONLY (FP Waiver or SPA)
- 1d one individual enrolled in any plan
- 1d one individual enrolled in partial Medicaid

If your assistance worker helped the consumer fill out paperwork to get an eligibility determination, you would also count the individual in the appropriate questions under section 1c.

Q26: If you talk to a client about all of her health insurance options and she comes back with her husband and two children to enroll them all in Medicaid, how do you count them?

A26: If your assistance worker works directly with the woman and three members of her family to educate them around their Marketplace and Medicaid options, determine eligibility, and enroll them in Medicaid, you would count them in the following categories:

- 1b; 4 individuals assisted (total number)
- 1c; 4 individuals who received an eligibility determination for any program
- 1c; 4 individuals who received an eligibility determination for Medicaid only
- 1d; 4 individuals enrolled in any plan
- 1d; 4 individuals enrolled in full Medicaid

Q27: If a family planning client works with a certified assister and selects a family plan, do I count her whole family as becoming enrolled?

A27: We'd like you to count only the individuals assisted directly (face-to-face, over the phone, by email, etc.). If you talked directly with one person, even if she selects a family plan, you would report having assisted one person. If she brings in other family members and you assist them all directly, then you can count those individuals.

Q28: In reference to slide 26 from the second data enrollment reporting webinar on March 17, 2015, would the partial Medicaid client also be counted in the total?

A28: Yes, this client would also be counted in the total for all enrollments. The *optional* questions are a subset of the total number, indicating in which kind of plan enrollment occurred. Everyone gets counted in the "total number" for the questions on total assisted, total eligibility determinations, and total enrollments.

Section 4: General Questions About Conducting Enrollment Activities

Q29: Do service sites need to continue tracking enrollment information even though the open enrollment period ended on January 31, 2016?

A29: Yes, services sites should continue tracking assists, eligibility determinations issued, and enrollments that occur between February 15 and March 31. Remember, enrollment into Medicaid programs is ongoing, and consumers are also able to enroll in the Marketplace on an ongoing basis if they have a qualifying life event (e.g., loss of a job, marriage, new birth or adoption of a child, etc.). OPA will continue to request enrollment data from all Title X service sites annually.

Q30: Can CACs enroll consumers in Medicaid (same question as "how can I find Medicaid training?")?

A30: Medicaid is a state-specific health insurance program, and training requirements vary accordingly. Some states do not have any required trainings for Medicaid, and some states have very stringent requirements for working with consumers on Medicaid enrollments. Please go to your state's

Department of Insurance and/or Department of Health websites to learn more about your specific state's Medicaid program requirements. If you still cannot get a firm answer around required training for your state, reach out to your grantee for assistance and ask them to get in touch with OPA.

Q31: Where can I find official federal resources on how to become a Certified CAC Organization and how to become a certified assistance worker?

A31: The Centers for Medicare and Medicaid Services hosts all of the information about becoming a Certified CAC organization on https://marketplace.cms.gov. The following link goes directly to the page with information about CAC organizations: https://marketplace.cms.gov/technical-assistance-resources/assister-programs/cac.html

The Medicare Learning Network hosts all of the required training for enrollment assisters: https://marketplace.medicarelearningnetworklms.com/Default.aspx
If you have additional questions not answered by this guidance document, please send specific questions to your Title X grantee and they can ask OPA directly for guidance.

Title X Network Enrollment Data Collection FAQs

***Data Due for all Title X service sites via SurveyMonkey: April 30, 2017**

FAQ's updated: January 10, 2017

Section 1: Guidance on How to Complete the OPA Enrollment Data Collection Survey

Q1: I heard that there was a webinar on Title X enrollment assistance data collection – where can I find a recording of this webinar?

A1: OPA has held two webinars for the Title X network on how to report health insurance enrollment efforts that have occurred at Title X service sites. The first webinar was held on November 10, 2014, and a recording of this webinar is archived on the Enrollment Assistance Community of Practice on fpntc.org. The second webinar was held on March 17, 2015, and can be found on the homepage of fpntc.org. All members of the Title X network who are involved in enrollment assistance as either assisters or data reporters are encouraged to watch either of the webinars – they contain the same content, so you may decide to watch either recording.

All Title X enrollment assisters are encouraged to create an account on fpntc.org and join the Enrollment Assistance community of practice. You can find a number of helpful enrollment resources, post discussion topics, and ask questions to the community and OPA. Please ensure you review the webinar for all Title X grantees and not for the enrollment assistance grantees, which have separate requirements.

Q2: The reporting period for the Title X Network data collection is April 1, 2016 – March 31, 2017, but I do not know whether my service site has enrollment data that goes back to April 2015. Do you have any suggestions for finding out this information?

A2: OPA understands that some service sites did not conduct enrollment efforts in 2016-2017 and/or may not have been tracking enrollment encounters with their clients after the end of the first open enrollment period. If the service site did not track this data and has no way of estimating it, just submit the data you did collect. **If your service site conducted zero enrollment activities during the data collection period you must still complete one survey for the site.**

Section 2: Who Needs to Complete the Survey and Which Data Should Be Included?

Q3: I have a site that does not do any enrollment of any kind. Should they still submit a form even though all of the info will be zero?

A3: Yes, each site must submit a completed survey form, even if they enter zeros for every question. Having each site submit a form, regardless of whether there was any enrollment activity, helps OPA ensure that we have an accurate denominator for the number of clinics in our network.

Q4: We have one Admin Site in the network of Title X sites that we (as grantees) oversee. Should they complete this data collection survey?

A4: A service site is either a clinic or a center that provides clinical care. If this administrative Title X site doesn't see patients or does not have existing or potential Title X clients visit to obtain enrollment assistance, then they do not need to submit a form. We would like a form from every service site that sees patients.

Q5: If we are a Title X sub-grantee with two clinics, do we submit two forms?

A5: Correct, each of the two clinics would submit its own survey form. A sub-grantee or grantee may choose to submit one form on behalf of each service site, or the service site may respond to the survey directly.

For example: If you are a grantee and have 10 sub-recipients with 10 sites each—your network of service sites would need to submit 100 completed surveys (one survey per clinic). As a Title X grantee, you may decide to delegate the task of responding to the survey to a sub-grantee or directly to the service site.

Q6: Do Title X sites located and operating in U.S. territories have to complete the survey?

A6: No, Title X sites located and operating in U.S. territories do NOT have to complete the survey.

Q7: If a clinic does not have any on-site assistance workers, but they are distributing information about enrollment, will they be expected to report using the survey in April 2017?

A7: Yes, all Title X service sites (clinics) must submit a completed survey, regardless of whether they conducted enrollment activities during the reporting period.

Q8: If my service site does not have any trained assistance workers and we referred patients to an external organization for help with enrollment; do we record any of these efforts?

A8: You are still required to submit a completed survey to OPA, but you would not count referrals to another organization in any of the data collection categories (i.e., report zeros in the survey). Only count enrollment efforts conducted by staff who received training to assist and enroll consumers. Such activities must have occurred at your Title X service site. Disseminating information (handing out brochures) or referring patients to another organization does not count as assisting consumers.

Q9: Does the OPA data reporting survey have to be completed by health center managers, or can the assistance workers at my service site fill it out?

A9: The data collection survey link will be sent to every Title X grantee and grantees will decide whether to fill out one survey for each of their service sites, or whether to pass the link on directly to the Title X service site for completion. Anyone with knowledge of the enrollment data may complete the survey, as long as they have a good understanding of the measures being asked. It does not have to be a manager at the service site.

Q10: There are a few FQHCs in my network and they have their own reporting requirements for HRSA to report similar enrollment data. Do these FQHCs need to report the same data to HRSA and to OPA? How do we avoid double counting?

A10: Yes, FQHCs that receive Title X funds should report all enrollment activities that occurred at their site to OPA. When presenting results of this survey, OPA will add a disclaimer to acknowledge that service sites may have reported the same data to other federal offices. OPA will use the data collected to provide us with an estimate of the impact that Title X service sites had on enrolling existing and potential Title X clients.

Q11: Will OPA expect FQHCs to determine the difference between assisting a Title X user versus a regular FQHC patient?

A11: No, sites can report the aggregate number of patients/consumers assisted at the Title X-recipient service site. They do not have separate Title X versus non-Title X clients.

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SECTION 4: GENERAL QUESTIONS ABOUT CONDUCTING ENROLLMENT ACTIVITIES

Q29: Do service sites need to continue tracking enrollment information even though the open enrollment period ended on January 31, 2016?

A29: Yes, services sites should continue tracking assists, eligibility determinations issued, and enrollments that occur between February 15 and March 31. Remember, enrollment into Medicaid programs is ongoing, and consumers are also able to enroll in the Marketplace on an ongoing basis if they have a qualifying life event (e.g., loss of a job, marriage, new birth or adoption of a child, etc.). OPA will continue to request enrollment data from all Title X service sites annually.

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The Medicare Learning Network hosts all of the required training for enrollment assisters: https://marketplace.medicarelearningnetworklms.com/Default.aspx
If you have additional questions not answered by this guidance document, please send specific questions to your Title X grantee and they can ask OPA directly for guidance.

If you have questions or concerns regarding this data collection request, please contact your agency consultant Darin McMillan at mcmilland@michigan.gov or 517-335-8891, Barbara Derman dermanb@michigan.gov or 517-335-8696, or Jessica Hamel at hamelj5@michigan.gov or 517-335-9263.

Thank you in advance for your assistance.

INSTRUCTIONS

Dear Title X Service Site,

Welcome to the 2016-2017 OPA Enrollment Assistance Data Collection Survey. You will be asked to report on enrollment efforts that you've conducted at your site between April 1, 2016 and March 31, 2017.

This survey is collecting site-level data. You should be reporting data for 1 service site per survey form.

If your answer to a particular question is zero, please enter "0" into the field. Do not leave blank.

If you have questions, please reach out to your primary Title X grantee. They may facilitate communications with OPA.

Thank you for your efforts in conducting these essential public health activities.

Office of Population Affairs (OPA)

Form Information:
OMB No. 0990-0423, expires 8/30/2017

Demographics

* 1. Name of service site for which you are reporting data (Note: A service site is the individual clinic or center; each service site should submit their own form)

* 2. City where the service site for which you are reporting data is located

* 3. State in which service site for which you are reporting data is located

* 4. Name of Grantee from which this service site receives the Title X funding

* 5. What is YOUR information, in case we need to contact you about the data reported for this service site?

Name:

Company:

Email Address:

Phone Number:

Outreach and Enrollment Assistance Workers

1a. Title X outreach and enrollment assistance workers are any grantee, subrecipient, or service site staff, contractors, or volunteer assistance personnel who are trained to facilitate enrollment of individuals into the health insurance marketplace, Medicaid, and/or CHIP.

* 6. 1a. Number of outreach and enrollment assistance workers who have successfully completed ALL required federal and/or state training

* 7. 1a. Number of outreach and enrollment assistance workers who have successfully completed all required federal and/or state training FOR FULL MEDICAID ONLY

* 8. 1a. Number of outreach and enrollment workers who have successfully completed all required federal and/or state training FOR PARTIAL MEDICAID PROGRAMS (ex: Family Planning Waiver Program)

* 9. 1a. Number of outreach and enrollment assistance workers who have successfully completed all required federal and/or state training FOR OTHER STATE SPECIAL PROGRAMS

* 10. 1a. Number of outreach and enrollment assistance workers who have successfully completed all required federal and/or state training FOR THE HEALTH INSURANCE MARKETPLACE

Outreach and Enrollment Assistance Provided

1b. This should include in-person education about affordable insurance coverage options (one-on-one or small group) and any other assistance provided to facilitate enrollment (e.g. setting up an account, filing affordability assistance information, receiving an eligibility determination, and/or selecting a qualified health plan or Medicaid/CHIP plan).

* 11. 1b. Number of individuals assisted by a trained outreach and enrollment assistance worker (Total)

12. 1b. Number of individuals assisted by a trained outreach and enrollment assistance worker FOR MEDICAID ONLY (Optional)

13. 1b. Number of individuals assisted by a trained outreach and enrollment assistance worker FOR PARTIAL MEDICAID ONLY (FAMILY PLANNING WAIVER PROGRAM OR SPA) (Optional)

14. 1b. Number of individuals assisted by a trained outreach and enrollment assistance worker FOR THE HEALTH INSURANCE MARKETPLACE ONLY (Optional)

Eligibility Determinations Provided

1c. Include all individuals who received an eligibility determination, even if the individual is not determined to be eligible for Medicaid/CHIP or for a subsidy through the health insurance marketplace.

* 15. 1c. Number of individuals who received an eligibility determination with the assistance of a trained outreach and enrollment assistance worker FOR THE HEALTH INSURANCE MARKETPLACE, MEDICAID, CHIP, FP WAIVER, State Planned Amendment (SPA), or other health insurance plan (Total)

16. 1c. Number of individuals who received an eligibility determination with the assistance of a trained outreach and enrollment assistance worker FOR MEDICAID ONLY (Optional)

17. 1c. Number of individuals who received an eligibility determination with the assistance of a trained outreach and enrollment assistance worker FOR PARTIAL MEDICAID ONLY (FAMILY PLANNING WAIVER OR SPA) (Optional)

18. 1c. Number of individuals who received an eligibility determination with the assistance of a trained outreach and enrollment assistance worker FOR THE HEALTH INSURANCE MARKETPLACE ONLY (Optional)

Individuals Enrolled

1d. An individual is considered "enrolled" if they have selected a plan and enrolled in it, regardless of whether or not they have paid the premium for the plan yet.

* 19. 1d. Number of individuals who enrolled (with the assistance of a trained outreach and enrollment assistance worker) IN ANY PLAN (e.g. selected a qualified health plan or Medicaid/CHIP) (Total)

20. 1d. Number of individuals who enrolled (with the assistance of a trained outreach and enrollment assistance worker) IN FULL MEDICAID OR OTHER PUBLIC INSURANCE PLAN (e.g. selected a qualified health plan or Medicaid/CHIP) (Optional)

21. 1d. Number of individuals who enrolled (with the assistance of a trained outreach and enrollment assistance worker) IN PARTIAL MEDICAID (Optional)

22. 1d. Number of individuals who enrolled (with the assistance of a trained outreach and enrollment assistance worker) IN A PRIVATE PLAN (e.g. selected a plan purchased in an exchange/marketplacae or through private insurance) (Optional)

Narrative Responses

Please provide up to 1/2 page of narrative to describe any major barriers and lessons learned during enrollment efforts.

* 23. Barriers:

Describe any major outreach and enrollment barriers you have encountered

* 24. Key strategies and lessons learned (for the current reporting period only):

Describe key strategies and lessons learned that have contributed to the success of your outreach and enrollment efforts

Title X Network Enrollment Data Collection FAQs

***Data Due for all Title X service sites via SurveyMonkey:** April 30, 2017

FAQ's updated: January 10, 2017

Section 1: Guidance on How to Complete the OPA Enrollment Data Collection Survey

Q1: I heard that there was a webinar on Title X enrollment assistance data collection – where can I find a recording of this webinar?

A1: OPA has held two webinars for the Title X network on how to report health insurance enrollment efforts that have occurred at Title X service sites. The first webinar was held on November 10, 2014, and a recording of this webinar is archived on the Enrollment Assistance Community of Practice on fpntc.org. The second webinar was held on March 17, 2015, and can be found on the homepage of fpntc.org. All members of the Title X network who are involved in enrollment assistance as either assisters or data reporters are encouraged to watch either of the webinars – they contain the same content, so you may decide to watch either recording.

All Title X enrollment assisters are encouraged to create an account on fpntc.org and join the Enrollment Assistance community of practice. You can find a number of helpful enrollment resources, post discussion topics, and ask questions to the community and OPA. Please ensure you review the webinar for all Title X grantees and not for the enrollment assistance grantees, which have separate requirements.

Q2: The reporting period for the Title X Network data collection is April 1, 2016 – March 31, 2017, but I do not know whether my service site has enrollment data that goes back to April 2015. Do you have any suggestions for finding out this information?

A2: OPA understands that some service sites did not conduct enrollment efforts in 2016-2017 and/or may not have been tracking enrollment encounters with their clients after the end of the first open enrollment period. If the service site did not track this data and has no way of estimating it, just submit the data you did collect. **If your service site conducted zero enrollment activities during the data collection period you must still complete one survey for the site.**

Section 2: Who Needs to Complete the Survey and Which Data Should Be Included?

Q3: I have a site that does not do any enrollment of any kind. Should they still submit a form even though all of the info will be zero?

A3: Yes, each site must submit a completed survey form, even if they enter zeros for every question. Having each site submit a form, regardless of whether there was any enrollment activity, helps OPA ensure that we have an accurate denominator for the number of clinics in our network.

Q4: We have one Admin Site in the network of Title X sites that we (as grantees) oversee. Should they complete this data collection survey?

A4: A service site is either a clinic or a center that provides clinical care. If this administrative Title X site doesn't see patients or does not have existing or potential Title X clients visit to obtain enrollment assistance, then they do not need to submit a form. We would like a form from every service site that sees patients.

Q5: If we are a Title X sub-grantee with two clinics, do we submit two forms?

A5: Correct, each of the two clinics would submit its own survey form. A sub-grantee or grantee may choose to submit one form on behalf of each service site, or the service site may respond to the survey directly.

For example: If you are a grantee and have 10 sub-recipients with 10 sites each—your network of service sites would need to submit 100 completed surveys (one survey per clinic). As a Title X grantee, you may decide to delegate the task of responding to the survey to a sub-grantee or directly to the service site.

Q6: Do Title X sites located and operating in U.S. territories have to complete the survey?

A6: No, Title X sites located and operating in U.S. territories do NOT have to complete the survey.

Q7: If a clinic does not have any on-site assistance workers, but they are distributing information about enrollment, will they be expected to report using the survey in April 2017?

A7: Yes, all Title X service sites (clinics) must submit a completed survey, regardless of whether they conducted enrollment activities during the reporting period.

Q8: If my service site does not have any trained assistance workers and we referred patients to an external organization for help with enrollment; do we record any of these efforts?

A8: You are still required to submit a completed survey to OPA, but you would not count referrals to another organization in any of the data collection categories (i.e., report zeros in the survey). Only count enrollment efforts conducted by staff who received training to assist and enroll consumers. Such activities must have occurred at your Title X service site. Disseminating information (handing out brochures) or referring patients to another organization does not count as assisting consumers.

Q9: Does the OPA data reporting survey have to be completed by health center managers, or can the assistance workers at my service site fill it out?

A9: The data collection survey link will be sent to every Title X grantee and grantees will decide whether to fill out one survey for each of their service sites, or whether to pass the link on directly to the Title X service site for completion. Anyone with knowledge of the enrollment data may complete the survey, as long as they have a good understanding of the measures being asked. It does not have to be a manager at the service site.

Q10: There are a few FQHCs in my network and they have their own reporting requirements for HRSA to report similar enrollment data. Do these FQHCs need to report the same data to HRSA and to OPA? How do we avoid double counting?

A10: Yes, FQHCs that receive Title X funds should report all enrollment activities that occurred at their site to OPA. When presenting results of this survey, OPA will add a disclaimer to acknowledge that service sites may have reported the same data to other federal offices. OPA will use the data collected to provide us with an estimate of the impact that Title X service sites had on enrolling existing and potential Title X clients.

Q11: Will OPA expect FQHCs to determine the difference between assisting a Title X user versus a regular FQHC patient?

A11: No, sites can report the aggregate number of patients/consumers assisted at the Title X-recipient service site. They do not have separate Title X versus non-Title X clients.

Q12: If a Title X clinic borrows certified enrollment assistance staff from another agency and those workers visit our clinic two days per week, can we count clients enrolled at our site in OPA reporting?

A12: Yes, it is acceptable to count consumers enrolled at Title X service sites even though the certified enrollment workers may be paid by other agencies/organizations. We want to capture the number of existing and potential Title X clients who were assisted and enrolled through a Title X site. Tracking enrollment data from shared assisters may be complicated, though, and you would want to ensure that assisters from the separate agency have a way to tell you how many consumers were assisted and enrolled just at your service site.

Q13: My service site is not legally allowed to report the number of people enrolled in a health insurance plan due to state-enacted legislation. We can still assist consumers in educating them about programs, though. How should we report data in this scenario?

A13: You should fill out the survey with as much data as you have. You will likely be able to answer the questions around the number of trained assistance workers you had present at your clinic, as well as how many consumers you assisted for the various insurance plan options in your state. Report zeros for the categories that do not have any data (such as the number of eligibility determinations issued or number of consumers enrolled). On the final page of the survey, in the narrative section, you can note that your state legislation prohibited you from tracking enrollments.

Q14: If my state doesn't require any special training for Medicaid or partial Medicaid, but clinic staff assist and enroll clients in those programs, do we count the number of people we assisted/enrolled in reporting?

A14: Yes, if your clinic staff do not have to be trained to assist consumers with enrollment into Medicaid programs in your state, you should include those individuals assisted, determined eligible, and enrolled in Medicaid or partial Medicaid with the help of such staff in the OPA data reporting.

Q15: My state doesn't allow our clinic staff to enroll clients into Medicaid (clients need to tum in their own forms to Medicaid), but our clinics assist clients by helping them fill out the paperwork. Do we count these activities in OPA reporting?

A15: Yes, the activities described in the above scenario qualify as assists. In the survey, you would report having a large number of assists, but a low (or zero) number of enrollments because you are unable to

track those enrollments. In such a case, you can use the narrative section of the form to explain the reason for the discrepancy between the number of assists and the number of enrollments in your clinic.

Q16: What if we have a sub-grantee that is conducting enrollment activities outside of their Title X clinic, such as at their immunization clinic?

A16: You should only report data for enrollment activities that occurred as part of the Title X service site's efforts. If your service site refers consumers out to another clinic that is not affiliated with Title X, you would not count that consumer in any of the reporting for your service site. Alternatively, if your Title X service site has trained assisters on staff who went to community events to work with consumers, you would count any resulting assists or enrollments in data reporting. Those assistance staff are affiliated with the Title X clinic, and thus contribute to the reporting.

Q17: If we assist a consumer who is outside of the Title X demographic, should we count them in the enrollment data reporting?

A17: Yes, you would count such individuals in reporting for OPA because Title X-supported staff worked directly with the consumer. It is important to note that assisters should help consumers of all ages who approach them for assistance with health insurance enrollment.

SECTION 3: DATA DEFINITIONS AND HOW TO COUNT INDIVIDUALS

Q18: How is OPA defining an individual as being "assisted" and can we count encounters that occur over the phone or by email?

A18: OPA is defining the "number of individuals assisted by a trained outreach and enrollment assistance worker" as an individual who received one-on-one or small group education tailored to the needs of each consumer. Assistance should include in-person education about affordable insurance coverage options (one-on-one or small group) and any other assistance provided to facilitate enrollment, e.g., setting up an account, filing affordability assistance information, receiving an eligibility determination, and/or selecting a qualified health plan or Medicaid/CHIP plan. You may count individuals who receive assistance in-person, over the phone, by email, or other two-way communication method in Title X reporting. The OPA definition of "assisted" aligns with the definition used by HRSA and other federal agencies.

Q19: How is OPA defining a consumer as "enrolled" in a health insurance plan with the assistance of a certified enrollment worker?

A19: OPA and other federal agencies are considering a consumer to be enrolled in a health insurance plan if the certified assistance worker has worked with the consumer to determine the plan that suits the consumer's needs, the consumer selects a plan, and the individual commits to enrolling/paying the premium. Because there is often lag-time between when the consumer selects the plan and signs up for the insurance and the time that the first payment is due for the premium, it is often not possible to conduct the follow-up that would be necessary to determine whether that consumer actually pays for the plan. Remember, the Federally-facilitated, Partnership, and State-based Marketplaces track whether consumers pay for their premiums, and the Marketplaces maintain official numbers for consumers enrolled in those health insurance plans.

Q20: We have a State-based Marketplace through which people can enroll in most Medicaid programs or Qualified Health Plans (if ineligible for Medicaid). When you say "Marketplace," are you referring to the Qualified Health Plans only?

A20: Yes, we are referring to insurance plans offered by the Federally-facilitated Marketplace (found on healthcare.gov) or by your State-based Marketplace.

Q21: If a clinic has staff who are not trained in the Marketplace (i.e., they are not certified application counselors or certified assistance workers), but staff do education and outreach for state-based Medicaid or other state programs, can they be counted as assistance workers for reporting purposes?

A21: If your state does not have training requirements for Medicaid or another state special health insurance program and your staff conduct education and/or enrollment activities with Title X clients, you can count those specific staff as assistance workers trained in Medicaid or partial Medicaid only. Only count the staff that work directly with clients for these programs – do not count every staff at the service site just because they are *technically* able to work with clients for Medicaid.

Q22: When filling out the number of trained assisters we had on staff during the reporting period, do you want us to count the percentage of an assistance worker's time if they only worked for part of the reporting period?

A22: Just report them as 1 assistance worker. We're asking for whole numbers – the number of trained assistance workers, not FTEs.

Q23: If the number of assistance workers we have has fluctuated over time, what number of workers would I report when I complete the survey?

A23: Count the maximum number of workers you had at any point during the reporting period who participated in enrollment activities at your service site.

Q24: My state has one application for our full state Medicaid program as well as for the state's Family Planning Waiver program. There is no distinction between the two programs on the application. How would we count those individuals we helped to enroll by filling out the application?

A24: Count individuals that you assisted/enrolled in this scenario as having enrolled in full Medicaid (the higher coverage option of the two program options).

Q25: If an individual is presumptively determined eligible for the state's Family Planning Waiver program and then is later approved for ongoing eligibility, how would we count this enrollment?

A25: You would count this person in the following categories:

- 1b one individual assisted (total number)
- 1b one individual assisted for partial Medicaid ONLY (FP Waiver or SPA)
- 1d one individual enrolled in any plan
- 1d one individual enrolled in partial Medicaid

If your assistance worker helped the consumer fill out paperwork to get an eligibility determination, you would also count the individual in the appropriate questions under section 1c.

Q26: If you talk to a client about all of her health insurance options and she comes back with her husband and two children to enroll them all in Medicaid, how do you count them?

A26: If your assistance worker works directly with the woman and three members of her family to educate them around their Marketplace and Medicaid options, determine eligibility, and enroll them in Medicaid, you would count them in the following categories:

- 1b; 4 individuals assisted (total number)
- 1c; 4 individuals who received an eligibility determination for any program
- 1c; 4 individuals who received an eligibility determination for Medicaid only
- 1d; 4 individuals enrolled in any plan
- 1d; 4 individuals enrolled in full Medicaid

Q27: If a family planning client works with a certified assister and selects a family plan, do I count her whole family as becoming enrolled?

A27: We'd like you to count only the individuals assisted directly (face-to-face, over the phone, by email, etc.). If you talked directly with one person, even if she selects a family plan, you would report having assisted one person. If she brings in other family members and you assist them all directly, then you can count those individuals.

Q28: In reference to slide 26 from the second data enrollment reporting webinar on March 17, 2015, would the partial Medicaid client also be counted in the total?

A28: Yes, this client would also be counted in the total for all enrollments. The *optional* questions are a subset of the total number, indicating in which kind of plan enrollment occurred. Everyone gets counted in the "total number" for the questions on total assisted, total eligibility determinations, and total enrollments.

SECTION 4: GENERAL QUESTIONS ABOUT CONDUCTING ENROLLMENT ACTIVITIES

Q29: Do service sites need to continue tracking enrollment information even though the open enrollment period ended on January 31, 2016?

A29: Yes, services sites should continue tracking assists, eligibility determinations issued, and enrollments that occur between February 15 and March 31. Remember, enrollment into Medicaid programs is ongoing, and consumers are also able to enroll in the Marketplace on an ongoing basis if they have a qualifying life event (e.g., loss of a job, marriage, new birth or adoption of a child, etc.). OPA will continue to request enrollment data from all Title X service sites annually.

Q30: Can CACs enroll consumers in Medicaid (same question as "how can I find Medicaid training?")?

A30: Medicaid is a state-specific health insurance program, and training requirements vary accordingly. Some states do not have any required trainings for Medicaid, and some states have very stringent requirements for working with consumers on Medicaid enrollments. Please go to your state's

Department of Insurance and/or Department of Health websites to learn more about your specific state's Medicaid program requirements. If you still cannot get a firm answer around required training for your state, reach out to your grantee for assistance and ask them to get in touch with OPA.

Q31: Where can I find official federal resources on how to become a Certified CAC Organization and how to become a certified assistance worker?

A31: The Centers for Medicare and Medicaid Services hosts all of the information about becoming a Certified CAC organization on https://marketplace.cms.gov. The following link goes directly to the page with information about CAC organizations: https://marketplace.cms.gov/technical-assistance-resources/assister-programs/cac.html

The Medicare Learning Network hosts all of the required training for enrollment assisters: https://marketplace.medicarelearningnetworklms.com/Default.aspx
If you have additional questions not answered by this guidance document, please send specific questions to your Title X grantee and they can ask OPA directly for guidance.

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

MEMORANDUM

DATE: March 27, 2017

TO: Family Planning Coordinators/Executive Directors

FROM: Deanna Charest, Manager
Reproductive and Preconception Health Unit

SUBJECT: 2017 DHHS Poverty Guidelines – FP-17-135

On January 26, 2017, the Department of Health and Human Services (HHS) published an update of the poverty guidelines as shown in the table below. Each agency must accordingly change their schedule of discounts to comply with these updated income guidelines.

According to the Michigan Department of Health and Human Services (MDHHS) Family Planning Standards and Guidelines, Section **8.4.2**, "A schedule of discounts **must** be developed for individuals with family income between 101% And 250% of the FPL to assure that services are billed based on ability to pay (42 CFR 59.5(a) (8))." MDHHS policy requires that the schedule of discounts **must** be developed with sufficient proportional increments to assure services are billed based on ability to pay. Sub-recipients **must** use the mandated quartile proportional increments that MDHHS distributes each year in developing their schedule of discounts. Sub-recipients may request and **must** receive an MDHHS approved waiver to use other proportional increments.

If you have any concerns related to the implementation of the FY 2017 sliding fee scale and/or if implementation by April 1 is a hardship for your agency, please contact your agency consultant: Darin McMillan at 517-335-8981, Barbara "Quess" Derman at 517-335-8696 or Jessica Hamel at 517-335-9263. Sliding fee scales are broken down by annual, monthly and weekly incomes.

Family Size	100% Poverty
1	$12,060
2	16,240
3	20,420
4	24,600
5	28,780
6	32,960
7	37,140
8	41,320
For family units with more than 8 persons, add $4,180 for each additional person.	

YEAR 2017
SLIDING FEE SCALE PERCENTAGE OF MAXIMUM CHARGE
BASED ON FAMILY SIZE AND INCOME
ANNUAL

Family Size	Less than or Equal to 100%	101% - 150%	151% - 200%	201% - 250%	251% and above
1	0 - 12,060	12,061 - 18,090	18,091 - 24,120	24,121 - 30,150	30,151
2	0 - 16,240	16,241 - 24,360	24,361 - 32,480	32,481 - 40,600	40,601
3	0 - 20,420	20,421 - 30,630	30,631 - 40,840	40,841 - 51,050	51,051
4	0 - 24,600	24,601 - 36,900	36,901 - 49,200	49,201 - 61,500	61,501
5	0 - 28,780	28,781 - 43,170	43,171 - 57,560	57,561 - 71,950	71,951
6	0 - 32,960	32,961 - 49,440	49,441 - 65,920	65,921 - 82,400	82,401
7	0 - 37,140	37,141 - 55,710	55,711 - 74,280	74,281 - 92,850	92,851
8	0 - 41,320	41,321 - 61,980	61,981 - 82,640	82,641 - 103,300	103,301
For each additional family member	$4,180	$6,270	$8,360	$10,450	$10,451
% to charge	0%	25%	50%	75%	100%

Services can not be denied based upon income or the inability to pay.

For the purposes of this report, the figures are rounded up (or down) for every dollar to the whole dollar.

This model fee scale is effective April 1, 2017. For additional information or help, please contact your agency consultant.

YEAR 2017
SLIDING FEE SCALE PERCENTAGE OF MAXIMUM CHARGE
BASED ON FAMILY SIZE AND INCOME
WEEKLY

Family Size	Less than or Equal to 100%	101% - 150%	151% - 200%	201% - 250%	251% and above
1	0 - 232.00	232.01 - 348.00	348.01 - 464.00	464.01 - 580.00	580.01
2	0 - 312.00	312.01 - 468.00	468.01 - 624.00	624.01 - 780.00	780.01
3	0 - 370.00	370.01 - 555.00	555.01 - 740.00	740.01 - 925.00	925.01
4	0 - 473.00	473.01 - 710.00	710.01 - 946.00	946.01 - 1,183.00	1,183.01
5	0 - 553.00	553.01 - 829.00	829.01 - 1,106.00	1,106.01 - 1,383.00	1,383.01
6	0 - 634.00	634.01 - 951.00	951.01 - 1,268.00	1,268.01 - 1,585.00	1,585.01
7	0 - 714.00	714.01 - 1,071.00	1,071.01 - 1,428.00	1,428.01 - 1,785.00	1,785.01
8	0 - 795.00	795.01 - 1,193.00	1,193.01 - 1,590.00	1,590.01 - 1,988.00	1,988.01
For each additional family member	$80.00	$121.00	$161.00	$201.00	$201.00
% to charge	0%	25%	50%	75%	100%

Services can not be denied based upon income or the inability to pay.

For the purposes of this report, the figures are rounded up (or down) for every dollar to the whole dc

This model fee scale is effective April 1, 2017. For additional information or help, please contact your agency consultant.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

DATE: June 9, 2017

TO: Family Planning Coordinators
Executive Directors

FROM: Deanna Charest, Manager
Reproductive and Preconception Health

SUBJECT: 2017 Mid-Year FPAR Submission – FP-137-17

Your mid-year submissions of the 2017 Family Planning Annual Report are due to the Michigan Department of Health and Human Services on Monday, July 17, 2017. Please note the following clarifications:

Table 14- Revenue Table:

- All local contributions that support Title X services should be listed on Line 9 – Local Government Support.
- Any Medicaid cost-based reimbursement dollars applied this reporting period should be identified and listed on a line separate from local funds. Lines 15 or 16 can be used to identify cost-based reimbursement dollars applied this reporting period.
- MCH Block Grant dollars applied to the provision of Title X services should be included with all other local contributions.

Table 9 – Cervical Cancer Screening Activities:

- Please note that Line 3 on Table 9 asks for the total number of Pap tests with an ASC or higher result, (i.e., all abnormal Pap tests). Line 4 asks for Pap tests with an HSIL or higher result (this is a subset of the number on line 3).
- The "Quality Care" section on Table 9 (Lines 5 and 6) are Michigan specific. Line 5 asks for the number of Abnormal Pap tests and should match Line 3. Line 6 asks for the number of Abnormal Pap tests that had timely follow-up. Ideally the reported number on Line

- 6 also matches Lines 5 and 3. If Line 6 does not match, there should be a note to explain any missed follow-up issue.

Table 15 – Unduplicated Number of Family Planning Users By Medicaid and PlanFirst! Coverage

- PlanFirst! benefits ended in June of 2016. Agencies should no longer report clients with PlanFirst! coverage on this table.

Please email your 2017 mid-year data to Judy Stiles at:

Judy Stiles
MDHHS/Division Maternal and Infant Health
Reproductive and Preconception Health Unit
P.O. Box 30195
Lansing, MI 48909
stilesj@michigan.gov.

If you have any questions or desire further clarification, please contact your Family Planning Consultants: Darin McMillan (mcmilland@michigan.gov), Jessica Hamel hamelj5@michigan.gov or Barbara "Quess" Derman (dermanb@michigan.gov)

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

MEMORANDUM

DATE: July 10, 2017

TO: Family Planning Coordinators/Executive Directors

FROM: Deanna Charest, Manager
Reproductive and Preconception Health Unit
Division of Maternal and Infant Health

SUBJECT: Family Planning Annual Plan – FP-138-17

Attached please find the Family Planning Program Annual Plan guidance as referenced in Michigan Department of Health and Human Services (MDHHS) agency contracts. FY '17-18 allocations were included in your agency contract released earlier this month.

Please review the annual plan guidance closely. The due date for this year's submission is **Friday, September 15, 2017**. Please e-mail your annual plan to Judy Stiles at stilesj@michigan.gov. The annual plan guidance references several required attachments for submission; these are available for download at http://www.michigan.gov/familyplanning under 'Information for Providers.' Please make efforts to limit annual plan documents by merging documents into one PDF when able.

If you have any questions, please contact your agency consultant: Darin McMillan at 517-335-8981 or mcmilland@michigan.gov, Quess Derman at 517-335-8696 or dermanb@michigan.gov, or Jessica Hamel at 517-335-9263 or hamelj5@michigan.gov.

Michigan Title X Family Planning

Annual Health Care Plan Guidance

The Annual Health Care Plan highlights a family planning agency's progress during the current fiscal year, along with identifying plans for next fiscal year, including priority population(s) and targeted service area(s), describing the agency's capacity to provide Title X services, and outlining service delivery plans. This document provides family planning agencies guidance on the submission requirements for the Annual Health Care Plan narrative and accompanying documents.

I. Program Description

A. Highlight significant program achievements, milestones, or other notable accomplishments during this past fiscal year.

B. Highlight program and community changes (e.g., staffing or administrative changes, supply issues, local policy/community issues, or provider relationships) that occurred this past fiscal year, focusing on service delivery and priority population(s) affects, and potential solutions.

II. Priority Population(s) and Target Service Area(s)

A. Provide a brief description of the agency's priority population(s) and target service area(s).

B. Insert the table below into this section's narrative and indicate the projected number of unduplicated users during calendar year 2018 for each table row. For demographic categories, refer to FPAR Table 1. For income level, refer to FPAR Table 4.

Demographic Category	Unduplicated Users 2018
Males	
Females	
Teens	
Income Level	**Unduplicated Users 2018**
At or below 100% of poverty	
Above 100% but no more than 150%	
Above 150% but not more than 200%	
Above 200% but not more than 250% of poverty	
Above 250% of poverty	

III. Agency Capacity & Staffing Structure

A. Provide a copy of the agency's current family planning organizational chart as an attachment.

B. Identify and report all services to be provided to clients under Title X by completing the *Family Planning Services Provided* document (See Family Planning website, 'Information for Providers').

C. Include the agency's current *Sliding Fee Scale* and Fee *Schedule*. Submit as an attachment.

D. Verify and submit the agency's coordinator information, main office hours, agency clinic location(s), and clinic hours of operation on the *Family Planning Agency Clinic Locations & Schedules* (Attachment A).

IV. Program Work Plan

A. Provide a brief progress report on the previous year's goals, objectives, and activities using the *Family Planning Work Plan Progress Report* (See Family Planning website, 'Information for Providers'), including community education and promotion activities.

B. Develop project goals and objectives for next fiscal year that are specific, measurable, attainable, realistic, and time specific (S.M.A.R.T.), and address Title X priorities. Submit on the required work plan format, *Family Planning Work Plan* (See Family Planning website, 'Information for Providers') as an attachment. Include at least one project goal and objective for Community Education Activities (See Section 11.2 of the *Michigan Title X Family Planning Standards and Guidelines Manual*) and at least one project goal and objective for Community Promotion Activities (See Section 11.3 of the *Michigan Title X Family Planning Standards and Guidelines Manual)*. Goals and objectives should reflect regional needs and engage priority populations.

V. Family Planning Advisory Council (See Section 11.1 of the *Michigan Title X Family Planning Standards and Guidelines Manual*).

A. Provide a brief description of the Advisory Council's purpose.

B. Include the following Advisory Council documents as attachments: next fiscal year's meeting schedule, member roster, and minutes from the *last* held Council meeting.

VI. Information and Education (I&E) Committee (See Sections 12.1 thru 12.7 of the *Michigan Title X Family Planning Standards and Guidelines Manual*).

A. Provide a brief description of the I&E Committee's function.

B. Include the current fiscal year's meeting schedule and the member roster as an attachment. The roster should indicate what community populations/groups the member represents (e.g., agency or professional organization name, or teen, male, client, or parent).

C. Describe the I&E Committee's review and approval process for educational materials, including review tools used, how reviewer feedback is gathered, and how member determinations are documented.

VII. Progress Report on Additional FY 2017 Title X Funds for Priority Projects t

A. Provide a brief progress report on the agency's Priority Projects goals, objectives, and activities using the *Quality Family Planning Service Project Progress Report* (See Family Planning website, 'Information for Providers'). *NOTE*: Each agency received $20,000 for a Priority Project 2017.

B. Provide a brief progress report on the agency's Third Party Payer Outreach project goals, objectives and activities using the *Quality Family Planning Service Project Progress Report* (See Family Planning website, 'Information for Providers') if your agency applied for the additional $3,000 in funding.

VIII. Electronic Health Records/Electronic Medical Record (EHR/EMR)

A. Provide the name and version of your EHR/EMR system along with the following details:

   i. Does your medical director utilize the EHR/EMR during the quality assurance process?

   ii. Do you currently utilize your EHR/EMR to manage program inventory?

IX. Third Party Agreements

A. Please list all contracted third-party payers (Medicaid Health Plans or Private Payers) enjoined by your agency.

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

MEMORANDUM

DATE: July 20, 2017

TO: Family Planning Coordinators
Health Officers/Executive Directors

FROM: Brent Davidson, M.D. Family Planning Medical Director
Reproductive and Preconception Health Unit

Deanna Charest, Manager
Reproductive and Preconception Health Unit

SUBJECT: Revised Breast and Cervical Cancer Screening Protocol for Title X Family Planning Sub-recipients – FP- 139-17

Enclosed is a revised Breast and Cervical Cancer Screening Protocol for all Title X funded sub-recipient agencies. The Family Planning Medical Advisory Committee supports the use of breast screening recommendations, endorsed by the American Cancer Society (ACS), American College of Obstetricians and Gynecologists (ACOG), National Comprehensive Cancer Network (NCCN) and the United States Preventive Services Task Force (USPSTF) for all Title X funded agencies. The revised Breast and Cervical Cancer Screening Protocol is effective immediately, but no later than September 1, 2017. See the attached revised protocol.

Changes include: Following current clinical breast exam (CBE) recommendations of the NCCN and to stay consistent with the Breast and Cervical Cancer Control Navigation Program (BCCCNP) guidelines, clinical breast exam beginning at age 25 thru 39 must be offered and/or provided at least every three years, even if no cervical cancer screening is performed.

Pap screening and management of abnormal Pap test results recommendations have not changed with this protocol. For the follow-up of abnormal Pap test results, continue to follow the American Society for Colposcopy and Cervical Pathology's (ASCCP) 2014 Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors. Algorithms are referenced in this document and may be found at http://www.asccp.org.

Please review this protocol with clinic staff and begin implementing no later than September 1, 2017.

NOTE: The revised Pap Screening Protocol will be placed on the Family Planning web site within the next few weeks at www.michigan.gov/familyplanning.

If you have questions, please contact Sue Montei, Nurse Consultant, at 989-550-2986 or montei626@gmail.com.

MDHHS
Michigan Department of Health & Human Services

FAMILY PLANNING PROGRAM

BREAST AND CERVICAL CANCER SCREENING PROTOCOL

Effective Date: September 1, 2017

I. INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) Family Planning Medical Advisory Sub-Committee supports the use of cervical cancer screening recommendations, endorsed by the American Cancer Society (ACS), American College of Obstetricians and Gynecologists (ACOG), and the United States Preventive Services Task Force (USPSTF) for all Title X funded agencies.

For the follow-up of abnormal Pap test results, the Family Planning Program will follow the American Society for Colposcopy and Cervical Pathology's (ASCCP) 2014 Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors. Algorithms are referenced in this document and may be found at http://www.asccp.org.

II. PAP SCREENING RECOMMENDATIONS

A. Screening Tests

- Pap test and speculum exam should be used for routine cervical cancer screening.
- Testing for cervical cancer is performed using either Liquid-Based Cytology or Conventional (slide) Pap test (no difference in screening interval is recommended). Consideration should be given to the use of High-Risk Human Papillomavirus (HR-HPV) testing in conjunction with cervical cytology for screening women 30 years of age and older.

B. Age to Initiate Screening:

- Screening for cervical cancer should begin at age 21 (NOTE: Women younger than 21 should NOT be screened regardless of the age of sexual initiation or other risk factors).
- Guidelines (algorithms) for women aged 21-24 years can be extrapolated to adolescents inadvertently screened. For example: If a transfer-in client was inadvertently Pap tested, and the Pap test was normal, re-Pap at age 21. Follow-up management for abnormal Pap results should conform to algorithms for ages 21-24. (See Section V. B 4)
- For women with HIV---see Section IV, Management of Women with Special Conditions

C. General Information

- The need for cervical cancer screening should not be the only basis for the onset of gynecological care.
- Adolescents must be able to obtain appropriate preventative health care, including, but not limited to, an assessment of health risks, counseling for pregnancy and sexually

transmitted disease (STD) prevention, contraception, and treatment of STD's; even if they do not need a Pap test.

- For the purpose of these guidelines an ADOLESCENT is defined as 20 years of age or younger.
- Adolescents and young women who have received the HPV vaccine should continue cervical cancer screening according to the current guidelines.
- Pelvic exams (speculum and bimanual) on females 13-20 years of age are no longer required unless medically indicated.
- Pelvic exams on females 21-39 should be performed at least at the time of routine pap testing and in-between if medically indicated
- If a Pap test is satisfactory and negative but NO endocervical cells are present, regular screening should be continued. "Regular" means according to cervical cancer screening guidelines. (See Section II. D)
- If a Pap test is satisfactory and negative but obscured/partially obscured by inflammation, repeat Pap test in 6 months. If 2nd Pap is abnormal, refer for colposcopy.
- If the Pap test is unsatisfactory, repeat Pap test in 2-4 months. If the 2nd Pap is unsatisfactory or abnormal, refer for colposcopy. NOTE: if 2nd Pap test is negative and satisfactory but lacks transformation zone cells, Pap test is considered NORMAL. Return to regular screening.
- For Chlamydia STD screening and testing (when a pelvic exam is not indicated) CDC guidelines for the use of urine testing, or vaginal self-swab instead of a pelvic exam and endocervical sample, may be used.
- Women aged ≥40 should have an annual bimanual pelvic and speculum exam.

D. ACS Recommendations for Cervical Cancer Screening: ("Regular/Routine Screening")

Age to Begin	Screening Exam	Screening Interval
Age 21-29	Conventional Pap Test OR Liquid Based Cytology (LBC)	Every 3 years (pap test alone)
Age 30-65	Conventional Pap Test OR Liquid Based Cytology (LBC)	Every 3 years (pap test alone)
Age 30-65	HPV AND Cytology "cotesting"	Every 5 years

Co-testing (Pap and HPV) is recommended for cervical cancer screening in women 30 years of age or older. If both tests are negative, testing then occurs every five years. For abnormal results, follow-up management guidelines may be found at http://www.asccp.org. **Title X funds may be used for HPV testing in accordance with the 2014 ASCCP guidelines.**

E. Relative Contraindications for Pap Testing: (Temporary Deferral)
   a. Heavy menstrual bleeding

b. Women less than 8 weeks post-partum (vaginal delivery) or 8 weeks post-abortion.
c. Visible cervical mass with bleeding--refer

PLEASE NOTE: Pap testing should NOT be deferred if vaginal discharge or signs and symptoms of vaginal infection are present.

III. CLIENT INFORMATION/EDUCATION

A. Regular cervical cancer screening (Pap test) is viewed as an important component of routine preventive care. Screening (via patient history) and testing for sexually transmitted infections, if indicated, should occur at the annual visit even if cervical cancer screening (Pap test) is not done.

B. Discuss the importance of Pap testing which includes:
- Frequency of Pap testing is based on recommendations from a nationally recognized professional organization, a woman's age and her Pap test history.
- Possible testing for STD.

C. Clients should be given copies of their Pap test and/or HPV test results due to the recommended screening interval time frames.

IV. MANAGEMENT OF WOMEN WITH SPECIAL CONDITIONS

A. Special Considerations:
- Women with a histologically-confirmed HSIL (colposcopy results of ≥CIN2), whether or not they receive treatment, continue cervical cancer screening (Pap test) on a regular basis for 20 years.
- Changes in cervical screening guidelines are for the general population and do not address women who are immunocompromised (e.g., infection with the human immunodeficiency virus).
  - Once HIV is diagnosed, Pap screening should begin for females who have initiated sexual activity regardless of age or at age 21 for women who have not initiated sexual activity.
  - The Pap test should be obtained twice during the first year after diagnosis of HIV infection.
  - After determining that baseline cervical screening results show no atypical cells or neoplasia, the Pap test should be repeated annually.
  - There are no data to support the use of HPV-testing for HIV-seropositive women >30 years to increase or decrease the frequency of Pap tests from 1 year intervals for women with normal cervical cytology.
  - Published data are insufficient to support use of HPV DNA testing in triage of ASC-US among HIV-seropositive women resulting in a recommendation to perform colposcopy for HIV-seropositive women with ASC-US.
  - Routine screening of HIV-seropositive women with vaginal cytology after hysterectomy for benign disease is not recommended.
  - An upper age limit on Pap cervical screening has not been established for HIV-seropositive women.
  - For follow-up, immunosuppressed women with abnormal cytology results should be managed in the same way as immunocompetent women.
- Women who had in utero DES exposure – continue ANNUAL cervical cancer screening (Pap test only) regardless of the testing method.

B. Provision of Screening and Diagnostic Services for Family Planning Women with Abnormal Pap Tests

1. Women age 21-39 years of age seen in any Family Planning/Title X clinic that have an abnormal Pap test result requiring colposcopy (using algorithms in Section V. B 4) can be referred to Breast and Cervical Cancer Control Navigation Program (BCCCNP) for diagnostic services to confirm or rule out a cervical cancer diagnosis.
2. Women age 40-64 seen in Family Planning/Title X Clinics for cervical services may be referred to BCCCNP for breast screening and diagnostic services (if needed), depending on agency caseload.

V. MANAGEMENT OF ABNORMAL PAP TEST RESULTS

A. Follow-up Process for Abnormal Pap test Results:

1. Clinicians should develop and implement a tracking system that will notify women of cervical screening results and follow-up diagnostic testing that is required. A method of contacting women without violating their confidentiality must be established at the first visit.
2. Documentation should be maintained in the medical record of all phone calls and letters to clients. If the pap results are HSIL, AGC, Squamous CC, or AIS and the client cannot be contacted, a certified letter should be sent to the client.
3. Title X requires that all women with an abnormal pap be notified within 6 weeks of obtaining the Pap test. Please note that the collaborative relationship with the Michigan BCCCNP requires that the colposcopy be completed within 90 days of performing the pap test, therefore it is recommended that follow-up be initiated as quickly as possible.

B. Clinical Management of Pap Testing Results

1. **NORMAL** cervical cytology with **ABNORMAL** appearance of the cervix
   a. Notify the client of the results of her pelvic examination and possible implication. This information should include the nature of the suspected disease.
      - To rule out cervical cancer, refer immediately for colposcopy with biopsy as indicated. Do not rely on cervical cytology results alone.
2. **UNSATISFACTORY** cervical cytology specimen
   Repeat Pap smear in 2-4 months. If second Pap test is unsatisfactory and/or abnormal, refer for colposcopy.

3. **ABNORMAL** cervical cytology report
   a. Notify the patient of the results of the Pap test and its implications as soon as possible but within 6 weeks of receipt of abnormal findings, including:
      - The nature of the suspected disease
      - What a precancerous lesion is
      - The need for further testing for definitive diagnosis before treatment
      - Treatment options available, benefits and risks of each
   b. Refer/arrange for repeat Pap test and/or diagnostic work-up and treatment based on Pap test results.

4. **FOLLOW-UP OF ABNORMAL CYTOLOGY RESULTS**:

The website http://www.asccp.org/ contains algorithms on the follow-up of:

- Unsatisfactory Cytology
- Cytology NILM but EC/TX Absent/Insufficient
- Management of Women ≥ Age 30, who are Cytology Negative, but HPV Positive
- Management of Women with Atypical Squamous Cells of Undetermined Significance (ASC-US) on Cytology
- Management of Women Ages 21-24 years with either Atypical Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)
- Management of Women with Low-grade Squamous Intraepithelial Lesion (LSIL)
- Management of Pregnant Women with Low-grade Squamous Intraepithelial Lesion (LSIL)
- Management of Women with Atypical Squamous Cells: Cannot Exclude High-grade SIL (ASC-H)
- Management of Women Ages 21-24 years with Atypical Squamous Cells: Cannot Exclude High-grade SIL (ASC-H) and High-grade Squamous Intraepithelial Lesion (HSIL)
- Management of Women with High-grade Squamous Intraepithelial Lesion (HSIL)
- Initial Work-up of Women with Atypical Glandular Cells (AGC)
- Subsequent Management of Women with Atypical Glandular Cells (AGC)
- Management of Women with No Lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 1 (CIN1) Preceded by "Lesser Abnormalities"
- Management of Women with No Lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 1 (CIN1) Preceded by ASC-H or HSIL Cytology
- Management of Women Ages 21-24 with No Lesion or Biopsy-confirmed Cervical Intraepithelial Lesion – Grade 1 (CIN1)
- Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 2 and 3 (CIN2,3)
- Management of Young Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 2 and 3 (CIN2,3) in Special Circumstances
- Management of Women Diagnosed with Adenocarcinoma in-situ (AIS) during a Diagnostic Excisional Procedure
- Interim Guidance for Managing Reports using the Lower Anogenital Squamous Terminology (LAST) Histopathology Diagnoses

VI. ADDTIONAL INFORMATION

A. Indications for Referral to a Qualified Colposcopist:

- Women age 24 and under requiring treatment for CIN2+
- Pregnant women with HSIL cytology
- Women with a significant cervical lesion in which "see and treat" may be indicated
- Women desiring fertility who, after excisional treatment, have recurrent or persistent cervical dysplasia
- Women who have had two "unsatisfactory for evaluation" tests 2-4 months apart
- Women with AGC (Abnormal Glandular Cells) or AIS (Adenocarcinoma in situ) on

cytology. Management follows the algorithm found at http://www.asccp.org
- Women with any gynecologic cancer should be referred to a Gynecologic Oncologist

VI. BREAST CANCER SCREENING

The Michigan Department of Health and Human Services Family Planning Medical Advisory Committee supports the use of breast screening recommendations, endorsed by the American Cancer Society (ACS), American College of Obstetricians and Gynecologists (ACOG), National Comprehensive Cancer Network and the United States Preventive Services Task Force (USPSTF) for all Title X funded agencies.

A. Clinical breast exam (CBE) beginning at age 25 thru 39 must be offered and/or provided at least every three years even if no cervical cancer screening is performed. For women age 21 and over, with suspicious breast masses, refer to BCCCNP for evaluation.
B. Clinical breast exam must be offered and/or provided annually starting at age 40. Refer to BCCCNP for suspicious breast masses for evaluation.
C. Mammogram recommendations:
   - Women aged 40-49 years: Individualize decision to begin biennial screening according to the client's circumstances and values.
   - Women aged 50-74 years: Screen every two years.

References:

1. American Cancer Society (ACS).
2. American College of Obstetricians and Gynecologists (ACOG)
3. United States Preventive Services Task Force (USPSTF).
4. American Society for Colposcopy and Cervical Pathology's (ASCCP)
5. NCCN Clinical Practice Guidelines in Oncology: Breast Cancer Screening and Diagnosis Version 12016 NCCN.org
6. Oeffinger KC et al. Breast Cancer Screening for Women at Average Risk; 2015 Guideline Update From the American Cancer Society JAMA. 2015; 314(15):1599-1614.
7. Sui, AL et al, Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement, Annals of Internal Medicine, Vol. 164, No.4, 16 February 2016.
8. The 2014 Updated Consensus Guidelines for the Management of Abnormal Cervical Screening Tests and Cancer Precursor.

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Date